SUMMARY NOTES

Maine Quality Forum Advisory Council
February 11, 2011

Present: Alex Dragatsi, Stephen Gefvert, Karynlee Harrington, Sue Henderson, Jeff Holmstrom, Frank Johnson, Robert Keller, Becky Martins, Lisa Miller, Elizabeth Mitchell, Al Prysunka, Ellen Schneiter, Peter Schultz, Doug Salvador, and David White

Item	Discussion	Decision/Action	Date Due
Minutes of Meeting	Robert Keller noted that Summary Notes from the September 10, 2010 meeting should be revised to reflect the resignation of Josh Cutler. Notes from the September and November meetings should be revised with the correct spelling for Jeff Holmstrom's name.	Minutes approved with edits	
New Director	Bob enthusiastically announced that Ellen Schneiter has joined the Dirigo Health Agency as director of the Maine Quality Forum. Bob noted that Ellen has a well established background in health policy and health care quality improvement. Ellen served as the Associate Director of the Maine Medical Assessment Foundation (MMAF), the non-profit research and health care quality improvement organization that provided the framework for the Maine Quality Forum. Following MMAF, Ellen joined Health Dialog, a provider of care management, healthcare analytics and decision support, continuing her work in the realm of health care quality improvement. She left that post to join the incoming Baldacci Administration's Office of Health Policy and Financing, where she was a key member of the health reform team. In 2006, Ellen left the Governor's Office and joined the management of the Department of Administrative and Financial Services, eventually being appointed as Commissioner of that agency. In that capacity, she served both as a member of the Dirigo Board of Trustees and a member of the Governor's Health Reform Steering Committee. Ellen holds a Masters degree from the University of Michigan School of Public Health. Ellen thanked Bob for the opportunity to lead this important work and to build on the substantial progress that has gone before her.	No action required	

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Dirigo Health Agency Update	Karynlee Harrington reported that DirigoChoice is open again for enrollment. Karynlee noted that 76 percent of new growth is coming from the small employee market, a decided shift from early dominance by enrollment of individuals. As of January 2011, DirigoChoice has a 16 percent share of the small group market in Maine, a trend that Kaynlee believes is attributable to the agency's competitive pricing and comprehensive coverage. Presently, about 26 percent of small group enrollment is non-subsidized, further attesting to its attractiveness when compared to other plans. Two bills are currently before the legislature related to DirigoChoice, one to repeal it (sponsored by Representative Treat) and one to reform DirigoChoice (sponsored by Representative McCain). The Dirigo Health Agency's position on both bills is to provide fair and complete information to inform the decision making process but to testify neither for nor against specific proposals. Effective February 14, the Governor appoint Joe Bruno as the Chair of the Dirigo Health Agency Board of Trustees. Mr. Bruno has served on the Board for the past 2.5 years, is president of Community Pharmacies, and previously served in the legislature.	Information only; no action required	
Shared Decision Making	Karynlee reminded members about a 2009 Legislative Resolve requiring the Maine Quality Forum to establish an advisory group to study the effectiveness, cost and quality of shared decision making. In accordance with the Resolve, an interim report was submitted in June 2010. The Study Group has been meeting these past months to update their findings, particularly as they relate to provisions of the Affordable Care Act as they pertain to shared decision making, and to make recommendations. The final report is scheduled to be submitted to the Legislature by the end of February. In its final report, the Study Group is recommending that a pilot be developed to further test how shared decision making can be reimbursed and integrated into practices. The Maine Quality Forum will establish a steering committee to further refine the concept and to	Information only; no action required	

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	explore possible funding sources. The MQF is particularly interested in integrating this work into Maine's all-payer medical home demonstration and provisions of health reform in the State. Karynlee thanked Bob Keller for his leadership in helping to shape the concept of a pilot. A lengthy discussion followed on the merits of shared decision making and perceived barriers to its use. Becky White cautioned the need for the pilot to address patients' failure to sometimes adhere to care plans that are developed in partnership with them. Sue Henderson acknowledged the problem of follow-through but emphasized that these dialogues do not always take into account the underlying social or behavioral issues that may make compliance difficult. Jeff Holmstrom noted that health teams were being established as part of Maine's patient-centered medical home demonstration to address these challenges and to support patients in managing their health conditions.		
Patient Experience of Care	The Maine Quality Forum is working with the Maine Health Management Coalition and Quality Counts to administer the Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG-CAHPS) to patients served by Maine practices. A Steering Committee met on January 27 to review strategies for obtaining sufficient responses that can be used for physician-specific public reporting while staying within a constrained budget. The Maine Hospital Association participated in that meeting and shared member experience in administering surveys and using data to compare physician quality. The Steering Committee described several approaches for doing this work: • Roll out the survey over a three year period, capturing 25-30% of the market each year. This approach raises questions about comparability given that data are obtained at different times. • Leverage existing hospital efforts by requesting hospitals to substitute their own surveys with the CG-CAHPS survey for several months during the year. That way, hospitals can continue to use	Information only .	

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	their own surveys while also contributing to a standardized statewide survey effort with limited additional cost. Regardless of the approach, everyone agreed that it is challenging to get patients to respond to surveys and that, with rare exception, few historically have been used to actually inform improvement efforts. Elizabeth Mitchell noted that patient experience is part of value-purchasing for CMS and that, for many employers and payors, patient feedback is becoming a large part of the quality proposition.		
Multi-Payor Advanced Primary Care Practice Demonstration	Karynlee reported on work that is underway as part of Maine's participation in the federal Medicare demonstration. This award will pay a monthly fee for Medicare beneficiaries receiving care from the 22 patient centered medical home (PCMH) pilot practices to provide enhanced care coordination services. In Maine, participation is expected to bring in $32M additional dollars over the course of the five-year demonstration. To qualify for these funds, Maine must create community care teams by October 2011 to work in concert with physicians to identify and support high-risk patients, facilitate self-care and transitions of care, and assist patients in connecting to community-based resources. Medicare's support of the community care teams is contingent on financial support by other payors as well. Elizabeth Mitchell reported that the project has strong support from Maine's commercial payors. Quality Counts has a separate grant from the Maine Health Access Foundation to design the composition and functioning of the community health team. A core design principle is to build on existing resources and to integrate physical and behavioral health. Initially it is envisioned that six community health teams will be established, some to support multiple medical home practices.	Information only	
Healthcare Associated Infections	Every year the Maine Quality Forum is required to report to the Legislature on progress in reducing the incidence of healthcare associated infections. Ellen Schneiter reported that the current draft report focuses on three major areas:	Information only	

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	• Infections related to surgical care • Healthcare associated infections not related specifically to surgical care • Methycillin Resistant Staphylococcus Aureus, or MRSA The surgical and HAI quality indicators tracked by the MQF indicate Maine hospitals are, on average, doing a good job addressing the risks associated with health care associated infections. All HAI measures are currently above national averages. MRSA prevalence has been documented for important high risk populations on a hospital by hospital basis. Ellen acknowledged weaknesses of the prevalence study which showed that hospitals were not consistent in how they conducted the initial screen of patients upon admission. In some cases, hospitals retested those that initially tested positive. Approximately one-third of those previously testing positive and which were subsequently retested showed up as negative. Inconsistencies in administration invalidate comparisons across hospitals. However, results provide each hospital with an indicator of the population that is most likely to pose risk for the transmission of MRSA to other patients and to health care workers within the hospital. Going forward, hospitals are required to continue to screen and submit data on high risk patients identified through the prevalence study. Bob Keller recognized Kathy Day from the audience. Kathy described LD 267, a bill sponsored by Representative Goode that is scheduled to go for public hearing in March. The bill would require that (1) findings from the prevalence study be publicly reported and (2) that all nursing facility patients, in addition to other high risk patients, be screened upon admission. Karynlee noted that the MQF would provide information and education on the issue to legislators but would not take a position on the legislation. Advisory Council members asked about the validity of the screening		

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	tests and how results can be used to assess the aggregate incidence of HAI in the state. Ellen noted that, because of inconsistencies in administration of the tests, aggregate totals are not valid. Doug Salvador noted that no national standard exists for defining high risk patients and that Maine used a threshold of 7 percent to determine when positive results should be classified as high risk. Questions arose about strategy in moving forward. Ellen noted that the MQF would be working with the Maine CDC and the MDRO Work Group to consider approaches for raising awareness and improving practice. There will also be further discussion on the best measures to use in not only monitoring safe practices within hospitals but also assessing functional and clinical outcomes. Elizabeth Mitchell suggested that the MQF include Pathways to Excellence in these discussions to build on the work of the Maine Health Management Coalition in this area.		
Public Comment	No public comments were made.		
Next Meeting	The next meeting of the MQF Advisory Council is scheduled for April 8, 2011.		